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Effects of Spirituality on Professionals at Risk of Developing Secondary Traumatic
Stress Disorder

Submitted by Stephanie Koslowski
May 2012

MSW Clinical Research Paper

This Clinical Research Project is a graduation requirement for MSW students At St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social work methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Dedication

This work is dedicated in memoriam to my son Michael who taught me the effects of spirituality on my life. Also, in memoriam to my mother Betty whose love and support helped me on my spiritual journey.

ACKNOWLEDGEMENTS

I would like to thank my committee members for all their help and guidance in this project. A special thanks to my committee chair Keith DeRaad whose help and guidance made this project possible.

Abstract

This study investigated the relationship between spirituality and secondary traumatic stress with counseling professionals in a Midwestern metropolitan area (N= 35, 34). This study utilized a sample of therapists, social workers, case managers, and counselors. Two surveys were utilized to measure the level of secondary traumatic stress symptoms and level of spirituality. Scores from the Secondary traumatic Stress scale were used as predictor variables, with scores from the Spiritual Involvement and Beliefs Scale – Revised as criterion variables. Demographic variables were also utilized to explore the relationship between spirituality and secondary traumatic stress symptoms. Measurement of central tendencies was conducted on both surveys. The results of this study implies that there may be a correlation between the two variables.

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Introduction

According to Bride (2007):

Social workers are increasingly being called on to assist survivors of childhood abuse, domestic violence, violent crime, disasters, and war on terrorism. It has become increasingly apparent that the psychological effects of traumatic events extend beyond those directly affected. Secondary traumatic stress (STS) is becoming viewed as an occupational hazard of providing direct services to traumatized populations.

Simpson and Starkey (2006) point out that the emotional demands of a counseling career are difficult as therapists are called upon to be empathic, understanding, and giving, yet they are expected to control their own emotional needs and responsiveness in their interactions with clients. Clinicians who engage empathically with clients who have been traumatized are at risk of experiencing compassion fatigue, a state of emotional, mental, and physical exhaustion (Figley, 1995; McCann & Pearlman, 1990; McCann & Saakvitne, 1995; Pearlman & MacIain, 1995).

Figley (1995) identified a counselor's well being as a contributing factor in the avoidance of compassion fatigue symptoms. Compassion fatigue is identical to Secondary Traumatic Stress Disorder and comparable to Posttraumatic Stress Disorder. Compassion fatigue will be discussed further later in this paper. In consideration of what makes up psychological well being Graham, Furr, Flowers, and Burke (2001) found the issue of spirituality as key interest in well being.

The purpose of this research is to examine secondary traumatic stress and the relationship spirituality plays as a possible coping mechanism.

Trauma

The term "trauma" originated in the Greek language and means "injury or wound" (Shauer, Neuner & Elbert, T., 2005). Initially, it was used in the field of medicine to describe bodily injury (e.g. physical trauma after an accident or traumatic brain injury).

Psychiatrists suggested that extremely stressful, life threatening events could be considered traumatic, and contribute to the onset of mental disorders, even without physical injury. Hence, trauma becomes the “wound of the soul” related to disordered brain functioning (Shauer, et al., 2005).

Psychological trauma is an affliction of the powerless, where the victim is rendered helpless by an overwhelming force at the at the moment of the trauma (Herman, 1992). Traumatic events overwhelm the victim and disrupt the ordinary systems of care that give people a sense of control, connection and meaning (Herman, 1992). According to the *Comprehensive Textbook of Psychiatry*, psychological trauma “is a feeling of intense fear, helplessness, loss of control, and threat of annihilation.” Due to the trauma, the victim may experience severe anxiety or arousal that was not there prior to the trauma (American Psychiatric Association, 2000, p. 220). Keep in mind that what constitutes as a traumatic event is in the interpretation of the individual experiencing it. Therefore, an event that may be traumatic for one individual may not be for another.

In the United States exposure to traumatic events ranges from 40% 81% in one’s lifetime, with 51.2% of women and 60.7% of men having been exposed to one or more traumas and 19.7% of men and 11.4% of women reporting exposure to three or more traumatic events (Bride, 2007). According to Ratna and Mukergee (1998) one in six women and one in ten men will experience sexual abuse during their childhood. The Federal Bureau of Investigation estimates indicate one in four women will be victims of sexual assault in their lifetime (Heppener, M.J., Good, G.E., Hillenbrand-Gunn, T.L., Hawkins, A.K., Hacquard, L.L., Nichols, R.K., et al., 1995). Among substance abusers seeking treatment , sixty percent to ninety percent report a history of sexual or physical abuse (Cohen & Densen-Gerber, 1982). Likewise, in the United Kingdom we see some

similar issues as reported by Hackwell (2009), according to the figures released by the county's police force under the Freedom of Information Act, 52 children were sexually assaulted and 145 children aged nine or under were also the victims of violence in the county of Gloucestershire between April 2008 and March 2009. Among the homeless population, 87 percent of homeless women with mental illnesses reported both childhood and adult abuse, with 97 percent reporting some form of abuse over the lifespan (Goodman, Dutton, & Harris, 1997).

Countertransference

The term countertransference originated from the psychoanalytic theory of Freud (1910) who wrote:

We have become aware of the “counter-transference,” which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it (p. 144-145).

According to Figley (1995) countertransference refers to a counselor's emotional reaction to a client as a result of the counselor's past life experiences and that reaction is specific to the counselor's experiences during or around counseling sessions. Corey (2001) described

countertransference as caregivers over identifying with their clients, seeing themselves in their clients or meeting their own needs through their clients. Countertransference has been linked as playing a key role in the treatment of trauma victims (Abarbanel, 1979; McCombie & Arons, 1980; McCombie, Bassuk, Savitz, & Pell, 1976; Schuker, 1979).

Secondary Traumatic Stress

According to Canfield (2005) Secondary Traumatic Stress (STS) is the effect of hearing emotionally shocking and disturbing stories from clients. Upon hearing these

types of stories professionals go through an internal process to make sense of these stories and to integrate the stories into their own cognitive schemas (Canfield, 2005).

According to Figley (1999) STS encompasses a list of symptoms identical to posttraumatic stress disorder (PTSD) such as intrusion, avoidance and arousal.

Posttraumatic Stress Disorder

According to Herman (1992) the various symptoms of PTSD fall into three main categories: “hyperarousal,” “intrusion,” and “constriction.” Herman (1992) elucidates hyperarousal as the persistent expectation of danger; intrusion as the inefaceable imprint of the traumatic moment; and constriction as the numbing response of surrender.

The American Psychiatric Association (APA) DSM-IV-TR (2000), criteria of PTSD are as follows: intrusion (or re-experiencing) symptoms including recurrent and intrusive recollections (e.g. images, thoughts, or perceptions) of the traumatic event or recurrent distressing dreams during which the event is replayed; as if the traumatic event were recurring in the form of illusion, hallucinations, flashbacks, or a sense of reliving the experience; and intense psychological distress or physiological reactivity when exposed to internal or external cues or reminders of the event. Avoidance symptoms involve persistent avoidance of stimuli associated with the trauma. The avoidance may result in efforts to avoid thoughts, feelings, or conversations with people that are reminders of the traumatic event. A person experiencing avoidance symptoms may be unable to recall an important aspect of the trauma. Symptoms may also include loss of interest or participation in significant activities, detachment or estrangement of others, restricted range of affect, and a sense of foreshortened future. Arousal symptoms include persistent symptoms of anxiety or increased arousal that were not present before the trauma, such as difficulty falling or staying asleep, irritability or outbursts of anger,

difficulty concentrating, hypervigilance, or exaggerated startle response.

If integration of hearing clients' shocking and disturbing stories is unsuccessful professionals may develop secondary traumatic stress disorder (STSD). Secondary traumatic stress is also known as compassion fatigue, or vicarious trauma (VT) in professional literature (Figley, 1999).

Vicarious Trauma

For purposes of this research vicarious trauma will be defined according to Figley (1995), vicarious trauma is a helping professional's traumatic reaction to specific client-presented information. Vicarious trauma focuses on the cognitive schemas or core beliefs of the professional treating the client and the way in which these may be altered as a response to the traumatic imagery presented by clients and empathic engagement. According to McCann & Pearlman (1990) vicarious traumatization occurs when a therapist's inner experience is negatively transformed as a result of empathic engagement with clients' trauma. Consequently, this may cause a disruption in the professional's view of self, others, and the world in general (McCann & Pearlman, 1990; Sabin-Farrell & Turpin, 2003). Previously, vicarious trauma was referred to as a countertransference reaction or as a form of burnout in professional literature (Figley, 1995, McCann & Pearlman, 1990). Vicarious traumatization occurs mainly among those who work specifically with survivors of trauma such as: trauma counselors, emergency medical workers, rescue workers, and crisis intervention workers. Burnout may occur among anyone in any profession (McCann & Pearlman, 1990).

Burnout

According to Tippary, Kress and Wilcoxon (2004) burnout is related to a feeling of being overloaded and progresses gradually as a result of emotional exhaustion. Figley

(1995) depicts burnout as a result of the general psychological stress of working with trauma clients. External causations of burnout are often attributed to large caseloads, the isolation of the work, and other bureaucratic factors states Canfield (2005). A work-climate view as a cause of burnout is described by Maslach and Leiter (1997) as the dislocation between what people are and what they do. Instead of blaming the individual, they assert that burnout is a problem associated with the social environment in which people work. They cite six specific work environment sources of burnout: work overload; lack of control; insufficient rewards; unfairness; breakdown community; and value conflict. Burnout however, does not lead to changes in trust, feelings of control, issues of intimacy, safety concerns, intrusive imagery, and esteem needs that are prevalent in VT and STS. Similar to VT burnout may result in emotional symptoms, physical symptoms, behavioral problems, interpersonal problems and work-related issues. Both VT and burnout are responsible for the decline in quality of care for clients as a result of counselor's decrease in concern and esteem for clients (Rauepaw & Miller, 1989).

Compassion fatigue (CF) is identical to STSD and comparable to PTSD in its symptoms (Figley, 1995). CF is an experience of those who help people in distress, and is traumatizing for the helper as it is a state of extreme tension and preoccupation with the suffering of those being helped (Figley, 1995). As a result of prolonged exposure to compassion stress CF is defined as “a state of exhaustion and dysfunction - biologically, psychologically and socially” (Figley, 1995, p. 253). Regardless of what researchers may focus on or what term is used to describe the experience, the common theme among STS, VT and CF is apparent, the result of professionals that work to relieve clients' emotional suffering is often the absorption of the client's traumatic material (Figley, 1995).

Individuals differ in their ability to tolerate stressors and thereby respond differently; some are able to tolerate stressors without negative manifestations while others are not (Figley, 1995). Research has identified the counselor's psychological well-being as a contributing factor in the avoidance of compassion fatigue symptoms (Figley, 1995). In researching what makes up psychological well being spirituality was of key interest in a study reported on by Graham, Furr, Flowers and Burke (2001). The authors, Graham, et al., (2001) reported on a survey conducted by the American Counseling Association found that counselors view spirituality as an important component of mental health. Additional research conducted by Graham et al., (2001) found a positive correlation between spiritual health and immunity to stressful situations when they examined the relationship between religion and spirituality in coping with stress. The question this research poses, therefore, is spirituality a protective factor for professionals who are at risk of developing secondary traumatic stress disorder?

Literature Review

This section provides a review of the literature related to secondary traumatic stress, vicarious traumatization, compassion fatigue, and spirituality. The review begins with a discussion of the risks of STS, research on various prevention theories and treatment as it relates to STS.

Risks

STS may be a concern of all social workers since forty percent to eighty one percent of the general population are at risk of experiencing trauma at some point in their lives (Bride, 2007). Social workers who provide direct services to trauma survivors are especially at risk for STS and developing STSD. In a sample of 600 social workers that were mailed surveys; Bride (2007) found that (97.8 percent) of the 294 who responded

indicated that their clients experienced trauma, and (88.9 percent) revealed that work with clients addresses issues related to their clients' traumas. Social workers overall are indirectly exposed to trauma as a result of their work, and therefore, may be at risk of experiencing STS symptoms. According to Bride (2007) secondary traumatic stress (STS) is considered an occupational hazard of providing direct services to trauma survivors. Secondary traumatic stress and STSD are not only detrimental to the professional experiencing it but it also negatively impacts and reduces the overall effectiveness of the treatment itself (Canfield, 2005). Another implication of STS and cause for concern was found in research done by Figley (1999) who contends that one of the reasons many human service professionals leave the field prematurely is because of the effects of STS and STSD. Radey and Figley (2007) suggest more must be done by social work educators to prepare future generations of social workers in understanding, preventing, and alleviating STS through improved screening, education, and supervision.

STS negatively influences the treatment process, the professional's own experiences of self and how they perceive the world (Canfield, 2005). STSD symptoms are similar to those of post traumatic stress disorder (PTSD) or acute stress disorder as defined in the *Diagnostic and Statistical Manual of the American Psychiatric Association* (APA, 2000).

Prevention

The Constructive Self-Development Theory (CSDT) suggests that the vicarious trauma (VT) experience is cause for concern both professionally and personally and recommends that the CSDT model be applied to a counselor's own experiences as a prevention measure and means of self-care (McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a).

CSDT Model Areas

Caseload. Counselors should limit the number of trauma clients on their caseload to help lighten the load of stress that the counselor has to deal with. Tipples, et al. (2004) reported that this suggestion is consistent with the research of Hellman, Morrison, and Abramowitz (1997) who stated that counselors reported less work-related stress with a moderate client caseload as opposed to a higher number of clients on their weekly caseload.

Peer supervision. Peer supervision groups are opportunities for trauma counselors to share VT experiences with other trauma counselors for normalization of VT experiences and social support. Because of confidentiality constraints counselors are unable to debrief with other support systems, whereas peer supervision offers an ethical manner for counselors to debrief (Tipples, et al., 2004).

Agency responsibility. Formal measures of informed consent regarding the risks involved in providing trauma counseling should be a standard employment procedure when hiring new trauma counselors. Professional development resources, including (a) opportunities for supervision, (b) consultation, (c) staffing, and (d) continuing education should be available for trauma counselors. Also suggested are the following employee benefits (a) insurance for personal counseling, (b) paid vacations, and (c) limiting the number of trauma survivors on the counselor's caseload. In addition, a pay raise may also be beneficial (Tipples, et al., 2004). Empirical evidence found by Chrestman (1995) suggests that increased income correlates positively with a decrease in symptoms of psychological distress. Also, the pay raise may be an indication of success as a counselor for some trauma counselors.

Education and training. Training focused on “traumatology” may be crucial in decreasing the effects of VT. Chrestman (1995) found empirical evidence that supported additional training decreased the symptoms of PTSD in trauma counselors (Tippany, et al., 2004).

Personal coping mechanisms. Tippany, et al. (2004) found reconnection to emotions increases the counselors’ personal tolerance level. Activities such as journaling, personal counseling, meditation, and receiving emotional support from significant others supports a counselor’s reconnection to emotions and increases their personal tolerance level. This increase in personal tolerance level is a recommended way of coping.

In a study conducted by Rosenberg (1991) humor was found to be an effective coping strategy used by emergency personnel. Experienced paramedics who were interviewed ranked humor as more important than talking with family and friends, having alone time, socializing, recreation, and hobbies, in coping with stress. The study also differentiated between types of humor; subjects reported the use of sick humor, humor defined as grim or morose as the preferred type of humor used.

Other effective coping strategies reported by Yassen (1995) are social activism, which can combat the feeling of powerlessness resulting from STS and provide a sense of shared mission with others, which can alleviate social isolation. Body work, maintaining the health of the body and nurturance, including massages, warm baths, therapeutic body work, wearing clothes that feel good, and surrounding yourself with a living environment that is comfortable and pleasant Life balance, engaging in a diversity of activities that are performed at moderate pace, relaxation, fun time, including vacations, contact with nature, hiking or walking in the park, and taking care of pets and plants. Creative expression, writing, drama, cooking, and music, meditation and spiritual

practice, can help cope with the effects of STS. Pearlman and Saakvitne (1995) found VT experiences may result in a loss of a sense of meaning in trauma counselors which in turn fractures their cognitive schemas and worldview. When a sense of meaning is lost, the trauma counselor may become cynical, nihilistic, withdrawn, emotionally numb, hopeless, and outraged. These are defenses produced by changes in the cognitive schemas of the trauma counselor's view of the world (e.g., the world is good; people are good) therefore creating a restructuring in the counselor's spirituality. Consequently, this may cause the counselor to experience sorrow, confusion, and despair. Research conducted by Pearlman and MacIain (1993) found that spirituality (e.g., finding meaning) provided an effective coping mechanism in managing the effects of their work. This study will focus on the influence of spirituality on secondary traumatic stress.

Spirituality

For the purpose of this research spirituality as defined by Ryan (1998, p. 40) will be referenced, "feeling connected or belonging in the universe, believing in a power outside one's self, searching for meaning and purpose..."

Research by Pearlman and Saakvitne (1995b) suggests that professionals with a "larger sense of meaning and connection" are less likely to experience vicarious trauma. An ever increasing amount of research has investigated the relationship of various spiritual principles to multiple aspects of health. Upon cumulative reviews of studies, Simpson (2005) suggests that there is a protective factor of spirituality to health (Simpson & Starkey, 2006). According to Simpson and Starkey (2006) theologians and researchers agree upon one thing: spirituality is not the same as religion. As defined by Simpson and Starkey (2006) *spirituality* is fundamental to understanding the ways in which one finds purpose in life. It is a unique, personally meaningful experience which is related to

religiosity but not reliant on any particular form of religion per se. Koenig, McCullough, and Larson (2001), define spirituality as:

The personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which (may or may not) lead to or arise from the development of religious rituals and the formation of community (p.18).

Spirituality and Wellness

Research has supported religion and spirituality as relevant to both physical and mental health. Cooper (2003) found the measurement of spiritual and religious involvements to be positively related to health and inversely related to physical disorders, mental disorders, and substance use disorders (Simpson & Starkey, 2006). According to Simpson (2005) an increasing number of studies indicate that those who are more spiritual experience a greater sense of well-being and life satisfaction, are able to cope better with stress, and less likely to complete suicide. Also relative to mental health, Simpson and Starkey (2006) state similar results have been reported by Koenig (1998) who found spirituality associated with higher self-esteem and lower depression. Numerous studies have shown the positive relationship of spirituality on various aspects of health such a cardiac surgery (Ai, Dunkle, Peterson & Bolling, 1998; Harris, Dew, Lee, Amaya, Buches, Reetz, & Coleman, 1995), immune function (Woods, Antoni, Ironson, Kling, 1999) and mortality (Clark, Friedman, & Martin, 1999; Oman & Reed, 1998). In addition, research has shown a rising interest of spirituality in both the popular and professional literature. A study conducted by Weaver, Pargament, Flannelly, and Oppenheimer (2006) found a significant increase in the number of research articles related to spirituality. A study by Stanard, Sandhu, and Painter (2000) noted the widespread interest of spirituality in contemporary American society and stated that

spirituality is becoming recognized in the field of counseling and psychotherapy.

Figley (1995) identified a counselor's psychological well being as a contributing factor in avoiding compassion fatigue symptoms. According to Simpson and Starkey (2006) Graham, Furr, Flowers, and Burke (2001) reported on a survey conducted by the American Counseling Association that reports counselors view spirituality as an important factor of mental health. In another study conducted by Graham, et al. (2001) they examined the relationship between religion and spirituality in coping with stress and found a positive correlation between spiritual health and immunity to stressful situations. A study conducted by Simpson (2005) revealed that no significant difference existed between mental health counselors, school counselors, private practitioners, or residential care counselors. These findings suggest that any counselor may be susceptible to the experience of CF. Furthermore, the results of this study support the existing spirituality literature (Bullock, 2002; Ellison, 1991; Ellison & Levin, 1998; Graham, et al., 2001; Koenig, 1999; Levin & Vanderpool, 1987; Levin, Larson, & Puchalski, 1997) Meisenhelder which suggests that spirituality is a source of hope and coping when facing, experiencing or recovering from particularly difficult times. According to Ryan (1998) individuals who lack spiritual beliefs are at risk of experiencing excruciating pain and feelings of rejection as they search for meaning in the world. Consequently, this suggests that spirituality is a source of hope, meaning, and purpose, especially during difficult times.

A study conducted by Simpson (2005) explored the relationship between a counselor's level of spirituality and the development of CF symptoms among counseling professionals in a southern state (N = 228). Participants of this study consisted of counseling professionals with a Master's degree or above. The sample consisted of

volunteers who were employees of 15 regional mental health centers, residential care facilities, private practices, and school counseling settings. The Spiritual Involvement and Belief Scale –Revised (SIBS-R) was implemented to measure the level of spirituality. The Compassion Satisfaction/Fatigue Self-Test for Helpers (CFST) was applied to predictor variable, with a measure of compassion fatigue serving as the criterion variable. Five additional predictor variables (spirituality score, age, years of experience, race, gender, number of trauma victims on caseload) were observed to determine what role they played in the potential relationship between spirituality and compassion fatigue.

The Pearson Product Moment Correlation was utilized to examine the relationship between the participant's scores on the spirituality instrument and the compassion fatigue instrument revealing spirituality scores correlating negatively with CF ($r = -.129, p = .027$). This correlation indicates an inverse relationship: as spirituality decreases compassion fatigue increases.

A correlation matrix was utilized to calculate the six variables. The number of trauma victims on a counselor's caseload was found to significantly correlate with CF. The spirituality scores showed significant negative correlation with CF scores indicating an inverse relationship.

A sample consisting of 223 professionals were surveyed to determine if a relationship exists between level of spirituality and compassion fatigue symptoms. Demographic variables such as, race, gender, occupation, years of experience, and number of trauma victims on the counselor's caseload were also examined to determine if they played a role in the occurrence of CF symptoms. The high number of clients served with a trauma history in conjunction with low spirituality scores presents the best fit model in predicting the onset of compassion fatigue symptoms.

Summary

Empirical research has documented that higher levels of spirituality have a positive impact on mental and physical health. Research has also documented those professionals who listen to trauma stories of their clients are at risk of developing secondary traumatic stress symptoms.

According to Simpson and Starkey (2006):

While there is an existing body of literature available in the separate areas of spirituality in counseling practice and prevention of compassion fatigue among counseling professionals, there is virtually no literature, conceptually or empirically linking the two areas (p. 4).

Due to the unavailability of literature, conceptually or empirically linking spirituality in counseling practice and the prevention of secondary traumatic stress; the purpose of this study is to determine whether or not a relationship exists between the level of spirituality and the level of secondary traumatic stress among helping professionals. The researcher theorizes that participants who score high on the SIBS-R will score lower on the STSS.

Conceptual Framework

The following lenses are of importance in this study as they will provide the reader with the theories involved in the development of this study and the researcher's theoretical worldview as it applies to this topic. These theories and concepts are assessed in the following lenses and demonstrate how the data will be impacted. The three lenses that will be analyzed are theoretical, professional and personal. These three lenses effect everything in this study.

Theoretical Lens

Figley (1995b) stated that a traumatized person may serve as a bridge that links the

traumatized feelings to the secondary victim. Furthermore, Figley (1995b) suggests that the pattern of response of a secondary victim is similar to that of the primary victim of a traumatic event. This theory emerged as the idea that traumatic information reported within therapeutic sessions creates mental imagery within the therapist as she or he empathizes with the client. Consequently, receiving knowledge of a traumatic event may be enough to result in traumatization.

An emergent body of research has investigated the relationship of a range of spiritual principles to multiple aspects of health and have concluded that there is a protective factor of spirituality to health (Meisenholder & Chandler, 2002). Similar results have been found with research pertaining to mental health. Spirituality has been linked with higher self-esteem (Krause, 1995), and lower depression (Fehring, Miller & Shaw, 1997; Koenig, 1998). Ellison (1991) reports that those who are more spiritual experience greater well-being and life satisfaction. Pearlman and Saakvitne (1995) imply that the development of secondary traumatic stress may be associated with the counselor's sense of spirituality. They contend that counselors with a "larger sense of meaning and connection" (Pearlman & Saakvitne, 1995b, p. 161) are less likely to experience secondary traumatic stress symptoms. With these theories in mind the researcher intends to study the impact that spirituality has on secondary traumatic stress symptoms.

The instrument chosen to measure secondary traumatic stress symptoms is the Secondary Traumatic Stress Scale (STSS) see Appendix C. The instrument chosen to measure the level of spirituality is the Spiritual Involvement and Beliefs Scale- Revised (SIBS-R) see Appendix D. The researcher theorizes that participants who score high on the SIBS-R will score lower on the STSS.

Professional Lens

As a social work graduate student the researcher's interest in investigating the between spirituality and secondary traumatic stress came about through the course of researching implications for professionals working with trauma survivors. In a qualitative research report the researcher interviewed a sexual assault counselor and found the counselor to be a spiritual person that worked with trauma clients for many years and had no intention of leaving her job. It occurred to the researcher that spirituality may be a factor in the coping mechanism of the sexual assault counselor and warranted further investigation. In several of the studies reviewed reference was made to literature available in counseling practice and prevention of secondary traumatic stress among counseling professionals but there is virtually no literature, linking the two areas conceptually or empirically. The instruments chosen for this research were discovered during the review of the implications for professionals working with trauma survivors. These instruments were chosen for their reliability and validity.

Personal Lens

Spirituality is a personal interest of the researcher as a person who is spiritual and interested in treating trauma survivors. The researcher's former Integrative Psychotherapy professor Merra Young summed up our existence perfectly when she said, "We are spiritual beings in a human experience." The other interest the researcher has on this topic is personal due to the interest in the effects of STS as a result of trauma work done with clients.

Method**Research Design**

The design of this study is quantitative. The purpose of this study is to examine the

relationship between spirituality and secondary traumatic stress, therefore, the hypothesis for this study is: As the social workers' level of perceived spirituality increases as measured by the Spiritual Involvement and Beliefs Scale-Revised, their perceived level of secondary traumatic stress will go down as measured by the Secondary Traumatic Stress Scale. This study incorporates an online survey into a correlational research design. Other variables considered are gender, age of the participant and percentage of participant's caseload impacted by trauma.

Population and Sampling

Respondents for this research are helping professionals, counselors, social workers, and therapists. An agency letter was utilized to acquire permission and distribution of the surveys from medium sized social service agencies in the Minneapolis-St. Paul area. Several agencies were sought for participation and an email of consent/agreement to forward the introduction letter with survey links was obtained from all agencies that participated. Emails were sent to the agency administrator or director with instructions to forward to agency staff fitting the criteria. An introduction letter with links to the surveys was emailed to a local list serve and posted. At least 180 individual introduction letters were sent by email with links to the surveys to prospective participants with the expectation of at least 30 being completed and returned. The protection of human subjects were adhered to as data received was anonymous through the use of an online survey service called Qualtrics.

Demographics

Three demographic questions were asked of the respondents: (1) What is your gender? (2) What is your education level? and (3) What percent of your caseload is impacted by trauma?

Instrumentation

The two instruments that were utilized for the purpose of this research were the Secondary Traumatic Stress Scale (STSS) and the Spiritual Involvement and Beliefs Scale-Revised (SIBS-R). The STSS will measure intrusion, avoidance, and arousal symptoms of secondary traumatic stress the dependent variable. The SIBS-R will measure the level of spirituality as the independent variable.

The Spiritual Involvement and Beliefs Scale-Revised (SIBS-R) is a 22 item self-administered measure of spiritual beliefs and actions that has an extensive focus and is widely applicable to a variety of religious traditions. The instrument measures four factors: (1) core spirituality, (2) spiritual perspective, (3) personal application/humility, and (4) acceptance/insight. The items are rated on a 7 – point Likert scale ranging in response from (7) agree strongly to (1) disagree strongly.

The original version of the SIBS (Hatch, Burg, Naberhaus, & Hellmich, 1998) a 39 item version was administered in New Zealand to 444 subjects by Faull and co-administered with the DUREL (Duke Religiosity Scale) it was administered to 304 medical students and a diverse sample of the elderly. Findings in the New Zealand subjects are as follows: Cronbach Alpha .95, Average SIBS Score not reported; Range of total score not reported, Factor Eigen Values 6.6, 2.5, 1.7, 1.4, 1.2, (rest ≤ 1.0). Findings in the Medical Students and Elderly are as follows: Cronbach Alpha .93, Average Sibs Score 203.2 ± 33.3 , Range of total score 113 - 263, Factor Eigen Values 23.8, 6.4, 3.0, 2.4, (rest < 2.0). Item analysis of the data indicated that most items had high correlations ($< .3$). No significant ceiling effect or restricted range was reported. Feedback from the elderly indicated that they felt the scale was too long and there was widespread agreement that 2 of the items were problematic with low correlations to total score.

Based on this data the scale was shortened to the best 22 items, selected from the retaining items that showed consistent factor loading in the different groups.

The Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004) was developed out of necessity in response to the need for a valid and reliable instrument to measure secondary traumatic stress symptoms in helping professionals. The STSS is a 17-item Likert type scale, ranging from (5) very often, to (1) never. The STSS was designed to measure symptoms characteristic of secondary traumatic stress: intrusion, avoidance, and arousal. The STSS has the potential to support our understanding of the impact of secondary traumatic stress on helping professionals, their clients, and the organizations in which they work.

A sample of 287 licensed social workers (48% response rate) completed a mailed survey that included the STSS. Three lines of inquiry were designed (1) the internal consistency of the STSS was examined (2) convergent and discriminate validity were assessed by examining the correlation between the STSS and measures of related and unrelated variables (3) the factorial validity of the STSS was examined through a structural equation modeling approach to confirmatory factor analysis.

The STSS established excellent internal consistency ($\alpha = .94$). Noteworthy correlations were found between the STSS and related variables. However, none were found between the STSS and unrelated variables. The confirmatory factor analysis supported the three-factor structure of the STSS. Therefore, the results provide data regarding the reliability and validity of the STSS.

Data Collection

The Secondary Traumatic Stress Scale was administered to a total of 42 respondents. An introduction letter email with a link to the survey was sent to the person in charge of

approving this request at one of the local social agencies. A similar email was sent to the person in charge of posting on a local list serve. An introduction letter with a link to the survey was sent to a mental health office supervisor who then forwarded it on to prospective participants in the mental health department. Emails were also sent to the persons in charge of forwarding the introduction letters to prospective participants at two other community mental health departments. Approximately 180 emails with introduction letters and links to the surveys were sent to individuals who met the criteria of prospective participant. The participant criteria consisted of helping professionals in counseling practice that provide direct service to clients.

The SIBS-R was administered to a total of 36 respondents. Similar to the STS survey emails were sent to the same list serve, agencies, and mental health departments. Approximately 180 emails with introduction letters and links to the survey were sent to the same individuals who met the criteria of prospective participant for the STSS. Likewise the participant criteria for the SIBS–R consisted of helping professionals in counseling practice that provide direct service to clients.

However, the inconsistent completion of both surveys prohibited the quantitative analysis of the original hypothesis of there being a relationship between the two variables.

Results/Findings

Demographics

Three demographic questions were asked of the study participants: 1) What is your gender? 2) What is your education level? 3) What percentage of your caseload is impacted by trauma? See Table 1 for demographic data.

Table 1.

What is your gender?			
Answer	Bar	Response	%
1 1. Male	0.142857	6	14%
2 2. Female	0.857143	36	86%
Total		42	100%
What is your education level?			
Answer	Bar	Response	%
1 1. Bachelors Degree	0.292683	12	29%
2 2. Masters Degree	0.609756	25	61%
3 3. Doctorate Degree	0.097561	4	10%
Total		41	100%
What percentage of your caseload is impacted by trauma?			
Answer	Bar	Response	%
1 1. 25% or less	0.071429	3	7%
2 2. 50%	0.285714	12	29%
3 3. 75%	0.238095	10	24%
4 4. More than 75%	0.404762	17	40%
Total		42	100%

Data Analysis

Qualtrics was the tool administered to collect the data anonymously. The data was then downloaded to an Excel XLS file and opened in SPSS. A Measure of Central Tendency was ran on the data from both surveys with the following results: the mean statistic value of the STS survey is 36.7429. The mean of the SIBS-R survey is 106.4412. In comparing the scores from the STS and the SIBS – R the mean score of the STS was lower than the score of the SIB – R which is what the researcher hypothesized. See the following two pages of data results.

STS Measure of Central Tendency

Descriptive Statistics							
	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
STSScale	35	18.00	55.00	36.7429	9.48790	-.221	.398
Valid N (listwise)	35						

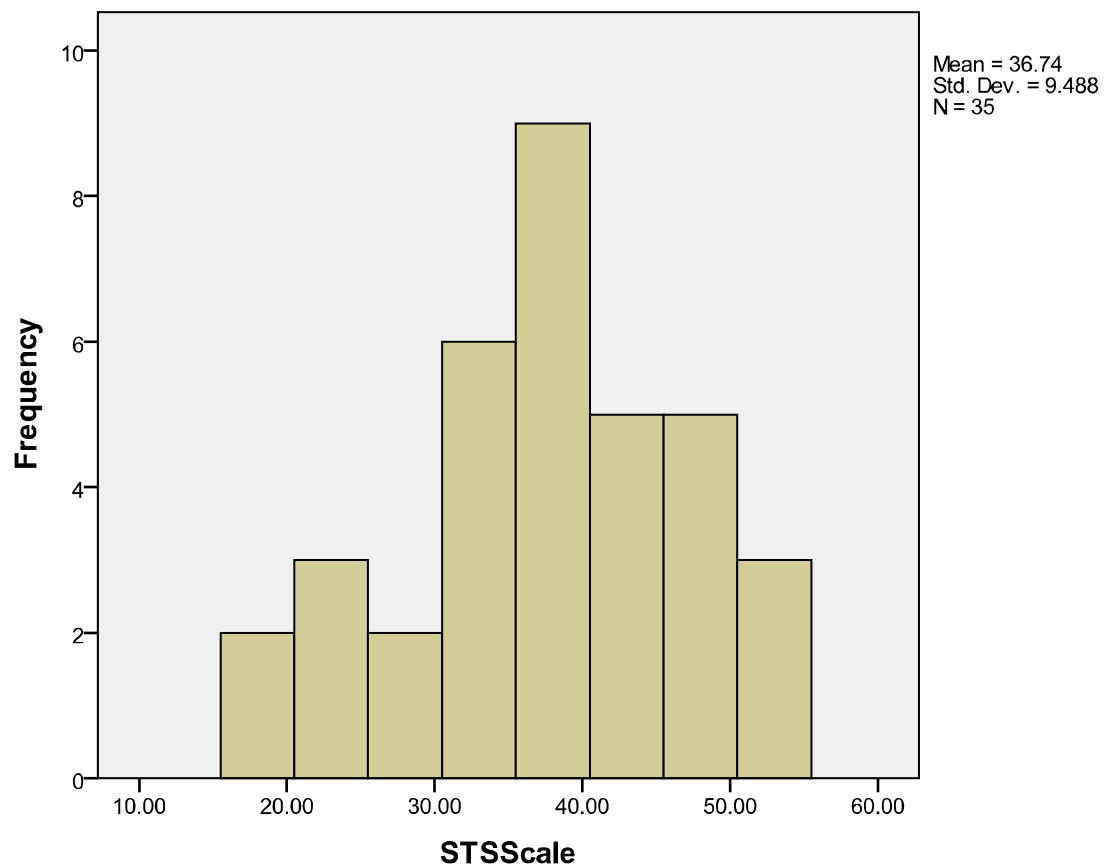


Figure 1. STS Scale

Minimum = 18, Maximum = 55

SIBS – R Measure of Central Tendency

Descriptive Statistics							
	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
SIBSRecoded	34	72.00	125.00	106.4412	13.76027	-.715	.403
Valid N (listwise)	34						

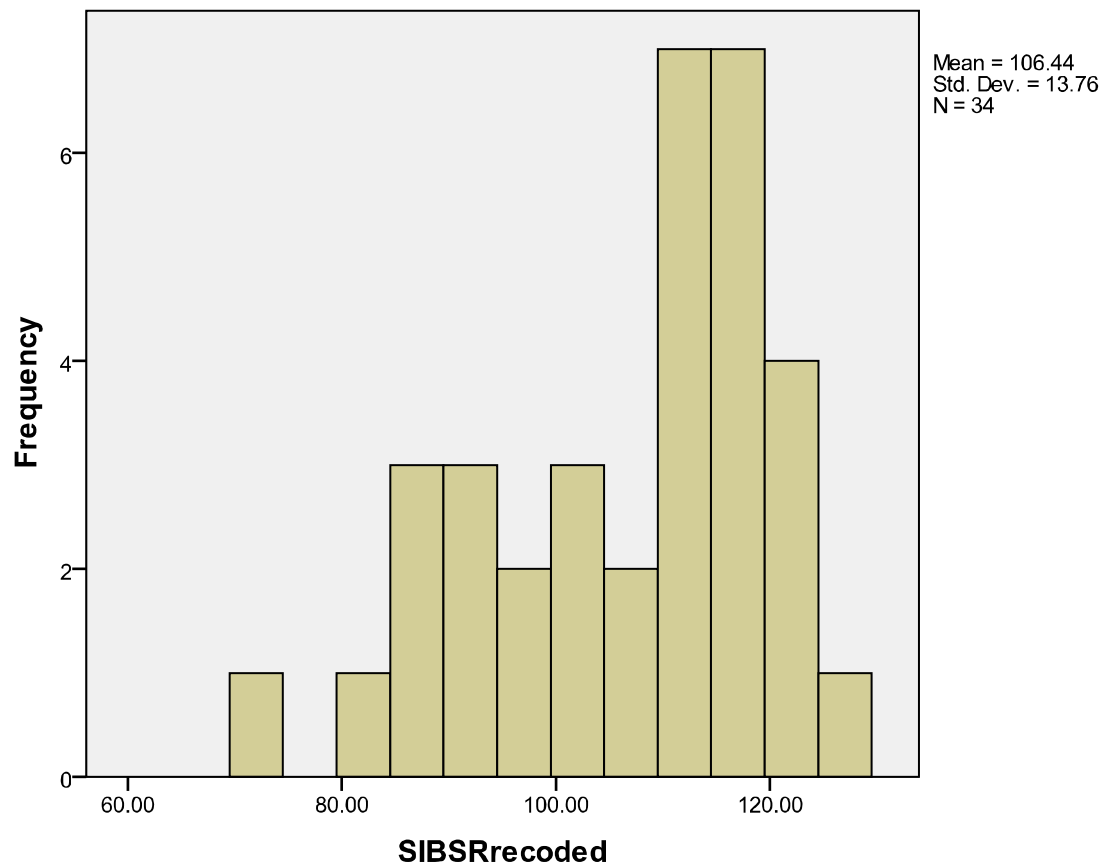


Figure 2. SIBS - R Measure of Central Tendency

Minimum = 72 Maximum = 125

Survey Data

The first statement from the STS survey I felt emotionally numb.... has 36% of respondents that indicated Never and 31% that indicated Rarely with only 55 indicating often and 0% very often. On the second STS survey statement, My heart started pounding when I thought about my work with clients... 31% indicated Never 33% indicated Rarely with only 2% indicating Very often. The third statement, It seemed as if I was reliving the trauma(s) experienced by my client(s)...31% responded Never with 40% responding Rarely with 0% indicating very often. The fourth statement I had trouble sleeping.... had 21% respondents replying Never and 7% with Very often response. The fifth statement, I felt discouraged about the future had 33% Rarely response and only 2% responding with Very Often. The sixth statement, Reminders of my work with clients upset me.... has 38% responding Occasionally, 7% responding Often and 0% responded to Very often. Statement 7. I had little interest in being around others.... 40% responded Never, 40% responded Rarely and only 2% responded to Very often. The eighth statement, I felt jumpy....has 44% Never respondents, 37% Rarely respondents and 0% responding to Very Often. The ninth statement, I was less active than usual.... 38% responded Never, 26% responded Rarely, and only 2% responded Very Often. The tenth statement I thought about my work with clients when I didn't intend to.... 48% responded Occasionally, with only 5% responding Very Often. The eleventh statement I had trouble concentrating..... 45% responded Occasionally, only 3% responded Often and 0% responded Very Often. The twelfth statement, I avoided people, places, or things that reminded me of my work with clients.... 39% responded Never, 32% responded Rarely, and 0% responded Very Often. The thirteenth statement, I had disturbing dreams about my work with clients....54% responded Never, 22% responded Rarely, and 0% responded Very Often. The fourteenth statement, I wanted to avoid working with some

clients.... 31% responded Rarely, 38% responded Occasionally, and 0 % responded Very Often. The fifteenth statement, I was easily annoyed.... 48% responded Rarely, and 0% responded Very Often. The sixteenth statement I expected something bad to happen.... 39% responded Never, 37% responded Rarely, and 0% Very often. The seventeenth and final statement of the survey, I noticed gaps in my memory about client sessions..... 40% responded Never, 43% responded Rarely, 0% responded Often and 0% responded Very Often.

The first statement from the SIBS- R, I set aside time for meditation and/or self-reflection, 36% of the respondents agreed, 17% Strongly Agreed and 0% Strongly disagreed. The second statement I can find meaning in times of hardship 36% Strongly Agreed, 6% Mildly Disagreed and 0% Strongly Disagreed. The third statement, A person can be fulfilled without pursuing an active spiritual life, 22% Agreed, 19% Disagreed and 11% Strongly Disagreed. The fourth statement, I find serenity by accepting things as they are, 42% Agreed, 22% Mildly agreed, 3% Disagreed, and 0% Strongly Disagreed. The fifth statement, I have a relationship with someone I can turn to for spiritual guidance, 40% agreed, 26% Strongly Agreed, 6% Disagreed, and 9% Strongly Disagreed. The sixth statement, Prayers really do not really change what happens, 11% Strongly Disagreed, 3% Agreed, 19% Mildly Disagreed, 19% Disagreed, and 19% Strongly Disagreed. The seventh statement, In times of despair, I can find little reason to hope, 0% Strongly Disagreed, 3% Agreed, 36% Disagreed and 42% Strongly Disagreed. The eighth statement, I have a personal relationship with a power greater than myself, 42% Strongly Agreed, 19% Agreed, 14% Disagreed, and 3% Strongly Disagreed. The ninth statement, I have a had a spiritual experience that greatly changed my life, 47% Strongly Agreed, 14% Agreed, 14% Mildly Agreed, 6% Mildly Disagreed, 6% Disagreed, and 6% Strongly

Disagreed. The tenth statement, When I help others, I expect nothing on return, 19% Strongly Agreed, 42% Agreed, 25% Mildly Agreed, 3% Mildly Disagreed, 6% Disagreed and 0% Strongly Disagreed. The eleventh statement, I don't take time to appreciate nature 3% Strongly Agreed, 8% Agreed, 8% Mildly Agreed, 28% Disagreed, and 44% Strongly Disagreed. The twelfth statement, I have joy in my life because of my spirituality, 25% Strongly Agreed, 25% Agreed, 25% Mildly Agreed, 3% Disagreed, and 8% Strongly Disagreed. The thirteenth statement, My relationship with a higher power helps me love others more completely, 28% Strongly Agreed, 28% Agreed, 8% Disagreed and 8% Strongly Disagreed. The fourteenth statement, Spiritual writings enrich my life, 28% Strongly Agreed, 25% Mildly Agreed, 14% Disagreed, and 11% Strongly Disagreed. The fifteenth statement I have experienced healing after prayer, 17% Strongly agreed, 31% agreed, 8% Disagreed, and 11% Strongly Disagreed. The sixteenth statement, My spiritual understanding continues to grow, 42% Strongly agreed, 22% Agreed, 6% Disagreed, and 8% Strongly Disagreed. The seventeenth statement, I focus on what needs to be changed in me not what needs to be changed in others, 28% Strongly Agreed, 39% Agreed, 6% Neutral, 0% disagreed, and 0% Strongly Disagreed. The eighteenth statement, In difficult times I am still grateful, 31% Strongly Agreed, 53% Agreed, 0% Disagreed, 0% Strongly Disagreed. The nineteenth statement, I have thought through a time of suffering that led to spiritual growth, 47% Strongly Agreed, 25% Agreed, 3% Disagreed, and 3% Strongly Disagreed. The twentieth Statement, I solve my problems without using spiritual resources, 9% Strongly Agreed, 20% Agreed, 26% Disagreed and 17% Strongly Disagreed. The twenty-first statement, I examine my actions to see if they reflect my values, 44% Strongly Agreed, 39% Agreed, 3% Disagreed, and 0% Strongly Disagreed. The twenty-second and last statement of the

survey, How spiritual a person do you consider yourself? (with a scale of 1 – 7 “7” being the most spiritual) 28% chose 6, 33% chose 5, 11% chose 3, and 8% chose 1.

Discussion

In this research the exploration of the relationship between a counselor's levels of spirituality and the development of STS symptoms was examined. The researcher hypothesized that as the levels of spirituality increases the STS symptoms decrease. Scores from the SIBS-R was utilized as the predictor variable, with a measure of the STS as the criterion variable. Research conducted by Simpson (2005) examined the relationship between counseling participants scores on the spirituality instrument and the compassion fatigue instrument which revealed scores correlating negatively with CF ($r = -.129, p = .027$). The correlation of the Simpson (2005) study indicates an inverse relationship: as spirituality decreases compassion fatigue increases. The mean scores of this study STS = 36.7429 and SIBS-R = 106.4412 implies such a correlation.

Social Work Practice Implications

STS may be a concern of all social workers since according to Bride (2007) forty percent to eighty one percent of the general population are at risk of experiencing trauma at some point in their lives. Social workers who provide direct services to trauma survivors are especially at risk for STS and developing STSD. Furthermore, social workers are indirectly exposed to trauma as a result of their work, and therefore, may be at risk of experiencing STS symptoms.

As previously noted by Figley (1999) one of the reasons many human service professionals leave the field prematurely is because of the effects of STS and STSD. Radey and Figley (2007) contend that more must be done by social work educators to prepare social workers in understanding, preventing, and alleviating, STS

through improved screening, education, and supervision.

Ryan (1995) theorized that individuals that lack spirituality are at risk of experiencing pain and feelings of rejection as they search for meaning in the world. Therefore, spirituality may be a source of hope, meaning, and purpose, especially during difficult times.

Cooper (2003) suggests, when spiritual and religious involvements have been measured, they have consistently found these concepts to be positively related to health and inversely related to physical disorders, mental disorders, and substance abuse disorders.

Simpson (2005) states an increasing number of studies indicate that those who are more spiritual experience a greater sense of well-being and life satisfaction, cope better with stress, and are less likely to complete suicide. Meisenholder (2002) suggests that spirituality is a source of hope and coping when facing, experiencing or recovering from particularly difficult times.

The results of this study imply that there is a possible correlation between levels of spirituality and secondary traumatic stress symptoms. Furthermore, the results of this study also imply that spirituality may very well be a protective factor and a means of self-care for those at risk of developing secondary traumatic stress symptoms.

Other recommended self-care mechanisms such as journaling, personal counseling, meditation, and receiving emotional support from significant others supports a counselor's reconnection to emotions and increases their personal tolerance level (Tippary, et al., 2004).

Social Work Policy Implications

Managers should limit the number of trauma clients on the counselor's caseload to

help lighten the load of stress that the counselor has to deal with, Tippany, et al. (2004). Hellman, Morrison, and Abramowitz (1997) assert that counselors reported less work-related stress with a moderate client caseload as opposed to a higher number of clients on their weekly caseload. Tippany, et al., (2004) suggest that social service agencies take responsibility for the following:

- A) Provide formal measures of informed consent regarding the risks involved in providing counseling as a standard employment procedure with new hires.
- B) Provide opportunities for supervision, consultation, staffing, and continuing education for counselors.
- C) Employee benefits: insurance for personal counseling, paid vacations, and in addition a pay raise may be beneficial.

Social Work Research Implications

A study conducted by Stanard, Sandhu, and Painter (2000) noted the widespread interest of Spirituality in contemporary American society and stated that spirituality is becoming recognized in the field of counseling and psychotherapy. Another study conducted by Graham, et al. (2001) examined the relationship between religion and spirituality in coping with stress and found a positive correlation between spiritual health and immunity to stressful situations.

As the results of this study imply, future research of the relationship of spirituality and STS could be beneficial as a possible prevention tool and means for the general health and well-being of counselors, therapists and the like. According to Simpson (2006) there is an existing body of literature available in the separate areas of spirituality in counseling practice and prevention of secondary traumatic stress among counseling professionals, but literature is lacking, conceptually or empirically linking the two areas. More research is needed in this area.

Strengths

Strengths of this research are that participants' data was gathered anonymously, and the study utilized existing measures. The instruments utilized in the research are short in length and have been tested for reliability and validity. The respondents provide direct services to the clients that have experienced trauma.

Limitations

The first limitation of this research is that the nature of human spirituality is ineffable, which makes it difficult to study. Often the definitions of spirituality and religion are confused. Respondents that chose to answer the surveys may have a higher interest or investment in the subject and not be representative of all people in the field. The availability of research to review was limited due to the limited data on studies measuring spirituality and STS symptoms. Due to a lack of funds a wider sample was not available for data analysis. Participants were limited to the twin cities metro area. Due to the time constraint the researcher was unable to procure a larger sample.

Quantitative analysis of the researcher's original hypothesis of a relationship between the two variables was not possible: because of incomplete data. Data from six respondents was not used and the uneven amount of respondents from both surveys coupled with the anonymity of the respondents rendered the testing of the correlation of STS and spirituality impossible.

Conclusion

Future research which would explore the two variables would enhance the knowledge of and level of spirituality is much needed. Future studies would benefit from a national population and sample to apply inferential statistics with enough data to make a reliable and valid comparison.

The literature suggests spirituality may be a protective factor for professionals from developing Secondary Traumatic Stress symptoms and Secondary Traumatic Stress Disorder which is why future studies are considered necessary.

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Appendix A

Cover Letter to Prospective Participants

**ST. CATHERINE UNIVERSITY/UNIVERSITY OF ST. THOMAS
SCHOOL OF SOCIAL WORK
Effects of Spirituality on Professionals at Risk of Developing Secondary Traumatic
Stress Disorder**

Dear _____:

My name is _____ and I am a graduate student in the social work program at St. Catherine University/University of St. Thomas in St. Paul, Minnesota. I am currently conducting research examining the level of spirituality among helping professionals and their level of secondary traumatic stress. This research is important work because there is virtually no literature, conceptually or empirically linking spirituality in counseling practice and the prevention of secondary traumatic stress.

Your participation in this study is completely voluntary and anonymous in nature. You were selected as a potential participant in this study because of your direct service to clients. If you choose to participate in this study, your involvement will entail answering questions on (2) short surveys one has 17 questions the other 22. The surveys will be completed online and should take approximately 15 minutes of your time to complete. No questions pertaining to your clients will be asked.

Information obtained through this survey will be anonymous; results to your survey will be stored in Qualtrics Survey Software and kept completely anonymous. Information obtained will be reported in a group format and no identifying information will be reported. If you have any questions or concerns as a result of your participation in this study, I would be happy to speak with you by phone or email. If you are willing to participate in this survey, please fill out the online questionnaire as soon as possible. Should you wish to withdraw your participation in this study, you may do so at any time.

I greatly appreciate your time and consideration of participation this study. Please feel free to contact me at _____ or via my faculty advisor, _____. This research project was approved by the St. Thomas University Institutional Review Board. If interested, you may request further information on the study and its results at a later date.

Thank you for your time and consideration of this study. Your participation is greatly appreciated.

Sincerely,

Graduate Social Work Student-St. Catherine University/University
of St. Thomas

APPENDIX B

CONSENT FORM

UNIVERSITY OF ST. THOMAS

Effects of Spirituality on Professionals at Risk for Secondary Traumatic Stress Disorder

[296382-1]

I am conducting a study about *secondary traumatic stress and the relationship spirituality plays as a possible coping mechanism*. I invite you to participate in this research. You were selected as a possible participant because you *counsel clients*. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: _____, _____, *Chair and, the University of St. Thomas' Graduate School of Social Work.*

The benefits of this research is assisting the researcher in acquiring data to either support or refute spirituality as a possible coping mechanism from developing secondary traumatic stress symptoms.

Procedures:

If you agree to be in this study, I will ask you to do the following things: fill out (2) online surveys. One will be the Secondary Traumatic Stress Scale an instrument that consists of 17 questions and the Spiritual Involvement and Beliefs Scale – Revised, an instrument consisting of 22 questions. The data you submit will be gathered anonymously through Qualtrics.

Risks and Benefits of Being in the Study:

The study has minimal risks. You will be given a survey to assess any secondary traumatic stress symptoms and a Spiritual Involvement and Beliefs Scale – Revised survey to assess spirituality.

Confidentiality: The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create includes an excel spreadsheet that will record data but no identifiable information pertaining to you.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with [*any cooperating agencies or institutions*] or the University of St. Thomas. If you decide to participate, simply fill out the online surveys. Should you decide to withdraw data after submitting the surveys your data will be anonymous and I will be unable to withdraw any data you submit.

Contacts and Questions

My name is _____. You may ask any questions you have now. If you have questions later, you may contact me at _____ or _____, chair at _____. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

Completing the online anonymous surveys will be considered as consenting to be a participant in this study. Therefore, the researcher will not be requiring signed consent forms from participants.

Appendix C

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb.....	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.....	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).....	1	2	3	4	5
4. I had trouble sleeping.....	1	2	3	4	5
5. I felt discouraged about the future.....	1	2	3	4	5
6. Reminders of my work with clients upset me..	1	2	3	4	5
7. I had little interest in being around others.....	1	2	3	4	5
8. I felt jumpy.....	1	2	3	4	5
9. I was less active than usual.....	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to.....	1	2	3	4	5

11. I had trouble concentrating.....1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.....1	2	3	4	5
13. I had disturbing dreams about my work with clients...1	2	3	4	5
14. I wanted to avoid working with some clients.....1	2	3	4	5
15. I was easily annoyed.....1	2	3	4	5
16. I expected something bad to happen.....1	2	3	4	5
17. I noticed gaps in my memory about client sessions.....1	2	3	4	5

Appendix D

Spiritual Involvement and Beliefs Scale – Revised (SIBS-R)

(Hatch RL, Spring H, Ritz L, Burg MA, University of Florida)

How strongly do you agree with the following statements? Please circle your response.

	Strongly Agree	Agree	Mildly Agree	Neutral	Mildly Disagree	Disagree	Strongly Disagree
1. I set aside time for meditation and/or self-reflection	7	6	5	4	3	2	1
2. I can find meaning in times of hardship.	7	6	5	4	3	2	1
3. A person can be fulfilled without pursuing an active spiritual life.	7	6	5	4	3	2	1
4. I find serenity by accepting things as they are.	7	6	5	4	3	2	1
5. I have a relationship with someone I can turn to for spiritual guidance.	7	6	5	4	3	2	1
6. Prayers do not really change what happens.	7	6	5	4	3	2	1
7. In times of despair, I can find little reason to hope.	7	6	5	4	3	2	1
8. I have a personal relationship with a power greater than myself.	7	6	5	4	3	2	1
9. I have had a spiritual experience that greatly changed my life.	7	6	5	4	3	2	1
10. When I help others, I expect nothing in return.	7	6	5	4	3	2	1
11. I have joy in my life because of my spirituality.	7	6	5	4	3	2	1
12. I have joy in my life because of my spirituality.	7	6	5	4	3	2	1
13. My relationship with a higher power helps me love others more completely.	7	6	5	4	3	2	1
14. Spiritual writings enrich my life.	7	6	5	4	3	2	1
15. I have experienced healing after prayer.	7	6	5	4	3	2	1
16. My spiritual understanding continues to grow.	7	6	5	4	3	2	1
17. I focus on what needs to be changed in me, not on what needs to be changed in others.	7	6	5	4	3	2	1

18. In difficult times, I am still grateful.	7	6	5	4	3	2	1
19. I have been through a time of suffering that led to spiritual growth.	7	6	5	4	3	2	1
20. I solve my problems without using spiritual resources.	7	6	5	4	3	2	1
21. I examine my actions to see if they reflect my values.	7	6	5	4	3	2	1

22. How spiritual a person do you consider yourself? (with "7" being the most spiritual)

7 6 5 4 3 2 1